



MEDICAL ASSISTANCE ADMINISTRATION
MATERNITY SUPPORT SERVICES
CLIENT SCREENING TOOL

				TODAY'S DATE	
CLIENT NAME LAST		FIRST	MIDDLE INITIAL		DATE OF BIRTH
STREET ADDRESS		CITY		STATE	ZIP CODE
TELEPHONE NUMBER	MESSAGE TELEPHONE NUMBER	DATE PRENATAL CARE STARTED	EXPECTED DATE TO DELIVER	ETHNIC GROUP	

1. Pregnancy History

- a. How many times have you been pregnant? _____
- b. Have you had premature labor or a premature birth before? ☐ Yes ☐ No
- c. How many of your children are currently living? _____ Living with you? _____
- d. What are your feelings about this pregnancy?
- _____
- _____
- _____

2. Childbirth/Parenting Education

- a. What would you like to learn about pregnancy, labor and delivery, and caring for your newborn?

3. Need For Transportation To Keep Medical Appointments

- a. How do you get around? ☐ Car ☐ Bus ☐ Other (Specify) _____
- b. How do you plan to get to medical appointments? _____
- c. Do you have transportation to go to community activities (shopping, seeing friends, attending groups or school?) ☐ Yes ☐ No

4. Need For Assistance To Care For Self And Infant

- a. Can you read directions/instructions? ☐ Yes ☐ No
- b. First Language _____ Second Language _____
- c. Physical Limitations: _____
- d. Describe where you live: (Examples: Rent, own your home, relatives, friends, shelter, motel, car)
- _____
- e. Other Needs: _____

5. Nutrition/Health Problems

- a. How many meals do you usually eat in a day? _____
- b. Do you have enough food? ☐ Yes ☐ No
- c. Do you skip meals? ☐ Yes ☐ No
- d. Where do you eat most meals? ☐ Cook at home ☐ Fast Food ☐ Shelter ☐ Other (Specify) _____
- e. Which beverages do you drink often? _____
- | | Yes | No |
|--|--------------------------|--------------------------|
| f. Is your blood low in iron (anemia)? | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Do you have high blood pressure? | <input type="checkbox"/> | <input type="checkbox"/> |
| h. Do you have diabetes now or during other pregnancies? | <input type="checkbox"/> | <input type="checkbox"/> |
| i. Have you had problems with weight gain/loss during your pregnancy? | <input type="checkbox"/> | <input type="checkbox"/> |
| j. Have you been told you have mental health problems? | <input type="checkbox"/> | <input type="checkbox"/> |
| k. Have you been depressed or know of others in your family that have? | <input type="checkbox"/> | <input type="checkbox"/> |
| l. Would you say that you are an anxious person? | <input type="checkbox"/> | <input type="checkbox"/> |
| m. Are you taking any prescribed medications? | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, name of medications: _____ | | |
| n. What regular exercise do you do? _____ | How often? _____ | |
| o. Do you have any other health concerns or medical conditions? | | |
| _____ | | |

6. Use of Alcohol, Drugs or Tobacco Products

- | | Yes | No |
|---|--------------------------|--------------------------|
| a. Do you smoke cigarettes? If yes, how many a day? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Are you exposed to secondhand smoke? | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Have you used alcohol just before or during this pregnancy?
How many drinks does it take to make you feel high (or "buzzed")? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Have you used drugs during or just before this pregnancy? | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Have you had problems with drugs or alcohol in the past? | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Does someone you live with have a drug or alcohol use problem? | <input type="checkbox"/> | <input type="checkbox"/> |

7. Support System

- a. Do you have someone you can count on for support during this pregnancy? ☐ Yes ☐ No
- b. Who do you talk to about difficult issues in your life? _____
- c. How does the baby's father feel about this pregnancy? _____
- d. What groups do you meet with or belong to? _____

8. Concern For Self and Child(ren)

- a. Do you worry about somebody mistreating you? ☐ Yes ☐ No
- b. Do you worry about anyone mistreating your child/children? ☐ Yes ☐ No

9. Coping

- | | Want
Help | 1 | 2 | 3 | 4 | 5 | Doing
Well |
|--|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|---------------|
| a. How would you rate your abilities/confidence in taking care of your physical and mental well-being? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| b. How would you rate your abilities/confidence in solving the problems in your life? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| c. How would you rate your abilities/confidence in handling the anger in your life? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |

10. Planning Ahead

- | | Yes | No | Don't
Know |
|--|--------------------------|--------------------------|--------------------------|
| a. How are you planning to feed your baby? <input type="checkbox"/> breast <input type="checkbox"/> bottle <input type="checkbox"/> both <input type="checkbox"/> don't know | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Are you planning to go back to work or school after birth? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Are you planning to use birth control after this birth? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

11. Have we covered everything? Is there anything else right now that is causing you to worry or be concerned about this pregnancy?

To Be Filled Out By Agency Staff

NAME OF HEALTH CARE (OBSTETRICAL) PROVIDER		TELEPHONE NUMBER	
ADDRESS	CITY	STATE	ZIP CODE
NAME OF MEDICAID HEALTH PLAN		PATIENT IDENTIFICATION CODE (PIC)	
NAME OF PEDIATRIC PROVIDER		TELEPHONE NUMBER	

Interviewer Observations

Date: _____

REVIEWED BY: